



5595 Memorial Avenue
 Oak Park Heights, MN 55082
 Phone: 651-439-0799
 Fax: 651-439-2516

Health Care Summary

Due 30 days after First Visit

Must be completed by health care source

Physician: _____ Phone: _____

I _____ (parent's name) Parent/guardian of
 _____ (child's name) give Little Victories permission
 to obtain a Health Care Summary and Immunization Record for
 the above listed child for enrollment in Little Victories.

 Signature Date

Date of Enrollment: _____ Name of Child _____ Date of Birth _____

Address _____ Telephone _____

Parent(s) or Guardian _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

What is the status of the child's... Vision _____

Hearing _____

Speech _____

Please list below the important health problems

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed by Other Med Source (name)</u>	<u>Requires Special Attention at Center</u>

Other information helpful to the child care program _____

Signature of Health Source: _____ Phone: _____

Address: _____ Date: _____